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Effective for inpatient services provided for dates of admission or service on and after July 1, 1991, hospital-based physicians services will no longer be reimbursed if billed to the Hospital program on the UB-82 claim form. These services must be billed to the Physician program in order to be reimbursed by the Department.

Effective with admission dates on and after November 1, 1991, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital costs using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds 60 percent; 101 to 150 beds - 65 percent; and 150+ beds - 70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1990 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

Effective July 1, 1992, each enrolled in-state hospital's fiscal period 1989 audited cost report will be used to determine its base period cost per admission. This report must be for a period of at least nine months. If the 1989 cost report is for a period less than nine months, then the latest audited cost report, containing at least nine months of data, will be used. If an audited cost report is not available, the cost report as filed by the hospital will be used initially. When the audited cost report becomes available and is reviewed, accepted or corrected, the hospital's rate and payment will be adjusted retrospectively. The base period cost consists of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see paragraph E). The second component consists of depreciation and interest for major movable equipment, building and fixed equipment; it is

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not inflated by a trend factor. The second component is added to the inflated operating component and total costs are divided by the number of admissions in the Department's paid claims file for the base period to determine the hospital's reimbursement rate. The Department no longer provides reimbursement for return on equity costs.

Effective for inpatient services provided for dates of admission or service on and after July 1, 1991, hospital-based physicians services will no longer be reimbursed if billed to the Hospital program on the UB-82 claim form. These services must be billed to the Physician program in order to be reimbursed by the Department.

Effective with admission dates on and after July 1, 1992, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital costs using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds - 60 percent; 101 to 150 beds - 65 percent; and 150+ beds -70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1991 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

Effective for dates of admission beginning July 1, 1993, each enrolled in-state hospital's fiscal period 1990 audited cost report will be used to determine its base period cost per admission. This report must be for a period of at least nine months. If the 1990 cost report is for a period less than nine months, then the latest audited cost report, containing at least nine months of data, will be used. If an audited cost report is not available the cost report as filed by the hospital will be used initially. When the audited cost report becomes

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available and is reviewed, accepted or corrected, the hospital's rate and payment will be adjusted retrospectively. The base period cost consists of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see Paragraph E). The second component consists of capital-related costs such as depreciation and interest for major movable equipment and building and fixed equipment; it is not inflated by a trend factor. The second component is added to the inflated operating component and total costs are divided by the number of admissions in the Department's paid claims file for the base period to determine the hospital's reimbursement rate. The Department no longer provides reimbursement for return on equity costs.

Effective with admission dates on and after July 1, 1993, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital cots using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds - 60 percent; 101 to 150 beds - 65 percent; and 150+ beds - 70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1992 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

Effective for dates of admission beginning July 1, 1994, each enrolled in-state hospital's fiscal period 1991 audited cost report will be used to determine its base period cost per admission. This report must be for a period of at least nine months. If the 1991 cost report is for a period less than nine months, then the latest audited cost report, containing at least nine months of data, will be used. If an audited cost report is not available, the cost report as filed by the hospital will be used initially. When the audited cost report becomes available and is reviewed, accepted or corrected, the hospital's rate and payment will be adjusted retrospectively.

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The base period cost consists of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see paragraph E). The second component consists of capital costs and it is not inflated by a trend factor. The second component is added to the inflated operating component and total costs are divided by the number of admissions in the Department's paid claims file for the base period to determine the hospital's reimbursement rate. The Department no longer provides reimbursement for return on equity costs.

Effective with admission dates on and after July 1, 1994, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital costs using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds - 60 percent; 101 to 150 beds - 65 percent; and 150+ beds -70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1993 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

7/1/95 Effective for dates of admission beginning July 1, 1995, each enrolled in-state hospital's fiscal period 1992 audited cost report will be used to determine its base period cost per admission. This report must be for a period of at least nine months. If the 1992 cost report is for a period less than nine months, then the latest audited cost report, containing at least nine months of data, will be used. If an audited cost report is not available, the cost report as filed by the hospital will be used initially. When the audited cost report becomes available and is reviewed, accepted or corrected, the hospital's rate and payment will be adjusted retrospectively.

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The base period cost consists of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see paragraph E). The second component consists of capital costs and it is not inflated by a trend factor. The second component is added to the inflated operating component and total costs are divided by the number of admissions in the Department's paid claims file for the base period to determine the hospital's reimbursement rate. The Department no longer provides reimbursement for return on equity costs. Medicaid cost and charge data used to determine per case rates will be based only on paid claims data.

Effective with admission dates on and after July 1, 1995, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital costs using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds - 60 percent; 101 to 150 beds - 65 percent; and 150+ beds -70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1994 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

8/15/96 Effective for dates of admission beginning August 15, 1996, each enrolled in-state hospital's fiscal period 1993 audited cost report will be used to determine its base period cost per admission. This report must be for a period of at least nine months. If the 1993 cost report is for a period less than nine months, then the latest audited cost report, containing at least nine months of data, will be used. If an audited cost report is not available, the cost report as filed by the hospital will be used initially. Prospective per case rates will be adjusted to deduct an amount per case for 90% of the average amount per case that Medicaid payments exceeded the cost of services provided during hospital

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8/15/96 fiscal years 1992 and 1993. When the audited cost report becomes available and is reviewed, accepted or corrected, the hospital's rate and payment will be adjusted retrospectively.

The base period cost consists of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see paragraph E). The second component consists of capital costs and it is not inflated by a trend factor. The second component is added to the inflated operating component and total costs are divided by the number of admissions in the Department's paid claims file for the base period to determine the hospital's reimbursement rate. The Department no longer provides reimbursement for return on equity costs. Medicaid cost and charge data used to determine per case rates will be based only on paid claims data.

8/15/96 Effective with admission dates on and after August 15, 1996, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital costs using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds - 60 percent; 101 to 150 beds - 65 percent; and 150+ beds -70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1995 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

Effective with dates of service on and after July 1, 1993, the Department will enroll and reimburse certified registered nurse anesthetists (CRNAs). CRNAs will be enrolled in and reimbursed through the Nurse Practitioner program. CRNA costs were excluded from hospitals' base year costs prior to calculating the per case rates effective on and after July 1, 1993.

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Effective with payment dates on and after July 15, 1993, claims for which a third party paid at or in excess of the Medicaid per case rate in effect for the dates of admission shall not be included in the paid claims data used to establish per case rates for dates of admission on or after July 1, 1993. The paid claims data used in the initial establishment of inpatient per case rates will be used when such rates are adjusted.

Effective with payment dates on or after October 18, 1993 and dates of admission on or after October 1, 1993, subject to the availability funds, the Department will adjust the prospective per case rate of the hospital with the highest number of inpatient Medicaid admissions in the previous fiscal year by adding to the hospital's per case rate, an add-on amount to reimburse for uncompensated inpatient Medicaid and medical education costs. The add-on amount is determined by dividing the uncompensated costs by the estimated inpatient Medicaid admissions for the reimbursement period.

C. Enrolled Non-Georgia Hospitals

Effective July 1, 1991, each enrolled non-Georgia hospital's fiscal period 1988 audited cost report will be used to determine its base period cost per case. This report must be for a period of at least nine months. If the 1988 audited cost report is not available, the cost report as filed by the hospital will be used initially.

When the audited cost report becomes available and is reviewed, accepted, or corrected, the hospital's rate and payment will be adjusted retrospectively. The prospective rate for enrolled non-Georgia hospitals will be calculated by dividing the allowable Medicaid inpatient cost from the hospital's base year (1988) by the number of Medicaid discharges, as reported in the cost report. This cost is the base year cost less nonallowable costs as reported in the nonallowable costs questionnaire. The base period costs consist of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see Paragraph E). The second

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component consists of depreciation and interest for major movable equipment and building and fixed equipment. This component is not inflated by a trend factor. The second component is added to the inflated operating component and the total cost is divided by the number of Medicaid discharges to determine the hospital's reimbursement rate. No reimbursement is provided for return on equity costs or the cost for services of hospital-based physicians.

Effective July 1, 1992, each enrolled non-Georgia hospital's fiscal period 1989 audited cost report will be used to determine its base period cost per case. This report must be for a period of at least nine months. If the 1989 audited cost report is not available, the cost report as filed by the hospital will be used initially. When the audited cost report becomes available and is reviewed, accepted, or corrected, the hospital's rate and payment will be adjusted retrospectively. The prospective rate for enrolled non-Georgia hospitals will be calculated by dividing the allowable Medicaid inpatient cost from the hospital's base year (1989) by the number of Medicaid discharges, as reported in the cost report. This cost is the base year cost less nonallowable costs as reported in the nonallowable costs questionnaire. The base period costs consist of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see Paragraph E). The second component consists of depreciation and interest for major movable equipment and building and fixed equipment. This component is not inflated by a trend factor. The second component is added to the inflated operating component and the total cost is divided by the number of Medicaid discharges to determine the hospital's reimbursement rate. No reimbursement is provided for return on equity costs or the cost for services of hospital-based physicians.

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A payment adjustment in the form of an intensity allowance of one percent per year is added to the trend factor for those enrolled non-Georgia hospitals designated as disproportionate share by the Medicaid agency in the state in which the hospital is located. Effective July 1 of each year, the Department will determine which non-Georgia hospitals are so designated. The full amount of the payment adjustment is included in rates effective for dates of admission of July 1, 1990, and after. This payment adjustment shall meet the requirements of Section 1923(c)(2) of the Social Security Act.

Effective with admissions on and after January 15, 1991, a payment adjustment will be made for enrolled non-Georgia disproportionate share hospital providers located within a 50-mile radius of the Georgia border. The payment adjustment amount is the difference between the calculated per case rate using Georgia Medicaid settlement data and the rate based on non-Georgia-specific settlement data. This adjustment will recognize any increase in case mix intensity resulting from serving Georgia Medicaid recipients.

Effective with admission dates on and after November 1, 1991, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital costs using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds - 60 percent; 101 to 150 beds - 65 percent; and 150+ beds - 70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1990 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

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Effective with admission dates on and after July 1, 1992, the Department will adjust inpatient payment rates by calculating reimbursable Medicaid capital costs using a minimum occupancy rate for bed-size categories as follows: 50 beds or less - 55 percent; 51 to 100 beds - 60 percent; 101 to 150 beds - 65 percent; and 150+ beds - 70 percent. Hospitals with an occupancy rate below the established minimums will have their reimbursable capital costs reduced proportionately based on the percentage difference between the actual occupancy rate and the minimum rate for the appropriate category. The actual occupancy rate will be determined from each hospital's fiscal year 1991 cost report on file with the Department. Rural hospitals with less than 100 beds will be excluded from the occupancy adjustment.

Effective for dates of admission beginning July 1, 1993, each enrolled non-Georgia hospital's fiscal period 1990 audited cost report will be used to determine its base period cost per case. This report must be for a period of at least nine months. IF the 1990 audited cost report is not available, the cost report as filed by the hospital will be used initially. When the audited cost report becomes available and is reviewed, accepted, or corrected, the hospital's rate and payment will be adjusted retrospectively. The prospective rate for enrolled non-Georgia hospitals will be calculated by dividing the allowable Medicaid inpatient cost from the hospital's base year (1990) by the number of Medicaid discharges, as reported in the cost report. This cost is the base year cost less nonallowable costs as reported in the nonallowable costs questionnaire. The base period costs consists of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see Paragraph E). The second component consists of capital costs and is not inflated by a trend factor.

The second component is added to the inflated operating component and the total cost is divided by the number of Medicaid discharges to determine the hospital's reimbursement rate. No reimbursement is provided for return on equity costs or the cost for services of hospital-based physicians.